

EMPLOYMENT VERIFICATION FORM

THIS FORM IS TO BE COMPLETED BY THE VICTIM'S EMPLOYER

CVR NUMBER:

VICTIM:
VICTIM SSN:
CLAIMANT:
ADDRESS:

DATE OF CRIME:

CLAIMANT INSTRUCTIONS:

- 1) Ask the victim's employer to complete and return this form to you.
- 2) Give completed form to your claim investigator.

EMPLOYER INSTRUCTIONS:

- 1) A claim is being made for wages lost as a result of an injury of the victim referenced above, and caused by a crime on the date shown.
- 2) Complete this form, verifying the actual earnings and return to the claimant.

Employer's Name: _____

Victim's Job Title: _____

Business Address _____

Victim's Supervisor _____

Phone No.: () _____

Victim employed: ☐ FULL TIME ☐ PART TIME ☐ OTHER HOW LONG EMPLOYED? _____ (Years/Months)

Victim absent from work: **FROM:** ____/____/____ **TO:** ____/____/____ = ____
Total weeks out of work

Date returned to work: ____/____/____ ☐ Did not return to work

INCOME/EARNINGS CALCULATION

WKLY INCOME: \$ _____ RATE OF PAY: \$ _____ per ☐ Hr ☐ Wkly ☐ Monthly ____ ☐ Other _____

OVERTIME/COMMISSION: \$ _____

Was employee paid for time off from work? ☐ Yes ☐ No DISABILITY INCOME : \$ _____

WORKMEN'S COMP: \$ _____ BEGINNING DATE _____ ENDING DATE _____

LOST WAGE INCOME: \$ _____ X _____ = \$ _____
Wkly Income Wks/Out of Wk
(\$ _____) (Less: Wkrs. Comp. or Social Security)
= \$ _____ **Lost Wages** (Adjusted)

VERIFYING SIGNATURE

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

(_____)_____
PHONE

TITLE